CASP CONNECTICUT ASSOCIATION OF SCHOOL PSYCHOLOGISTS

AFFILIATED WITH THE NATIONAL ASSOCIATION OF SCHOOL PSYCHOLOGISTS

Written Testimony of

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Education Committee

Good afternoon. My name is AnnMarie Duffy and I am submitting the following testimony on behalf of the Connecticut Association of School Psychologists (CASP) on H.B. No. 5347 **AN ACT CONCERNING THE REPORTING OF CHILDREN PLACED IN SECLUSION**

I am here today to support H.B. 5347 to effectively monitor and collect data regarding use of seclusion/ restraint in emergency situations to use formulating future policy. CASP supports KTPs desire to understand the troubling number of incidents reports as seclusion in 2009-2010.

I would like to thank the Children's Committee for raising a bill that addresses the reporting requirements of children placed in seclusion and raise awareness about the real need for highly trained staff to respond with compassion and respect in situations where physical safety is at risk. Lack of proper training could lead to instinctive reactions that become punitive.

Safety is critical to a positive school climate promoting academic learning and social emotional growth. The adults who are present in a school setting have options when behavioral or mental health needs become challenges that pose safety concerns. These options should usually range from least to most restrictive. Option 1) Positive behavioral supports and option 2) De-escalation techniques that are proven to be effective methods in reducing problem behaviors and can actually increase classroom learning would/ should happen first. Hopefully effective methods of positive behavioral support and proven de-escalation techniques reduce the problem behavior and refocus learning.

There are times when these techniques are not effective and do not result in defusing the behavioral episode. On the occasion behavior poses imminent threat of physical harm to self or others, seclusion becomes a last resort. De-escalation strategies should be continued with staff speaking respectfully to instruct the child about techniques to self-soothe and regain emotional

control. The possible negative side effects of physical restraint have to be considered each time.

There is a small percentage of the special education population that exhibit extremely intense, prolonged, dangerous behavior towards themselves or others to self and others and do not respond to extensive attempts by highly trained mental health and educational professionals to use de-escalation strategies (e.g., talking calmly and supportively, offering soothing statements, offering to remove the source of the stressor if possible, offering a quite calm place to "take space," offering the opportunity to call a parent, offering the use of occupational therapy equipment, offering supportive physical prompts, applying a brief supportive hold, offering the opportunity to talk with someone, take a walk, etc.). Examples of when seclusion may become necessary may include violently throwing furniture around the room/office/hallways, running out of the building in a highly agitated state, physically attacking other children or adults in the vicinity, and self-injurious behaviors (e.g., violent head banging).

There needs to be a more definitive understanding about what seclusion/ restraint means and how it is implemented. Does seclusion refer to the disruptive student who sent or chooses to go to In School Suspension instead of becoming belligerent and losing self-control or a child locked in a scream room for a minor infraction? Again, seclusion should refer to an emergency intervention used only to maintain physical safety.

Staff needs to be properly trained to implement physical restraint and seclusion in a compassionate and flexible manner that accounts for the particular psychological needs of the child and the particular characteristics of the behavioral episode. The therapeutic rationale for the use of seclusion is to keep the child and everyone else safe and to present the child with a physical and interpersonal environment that is conducive to regaining behavioral control when no other options are effective.

Seclusion is a crisis intervention procedure, not a therapeutic treatment. The semantics-treatment and intervention can be misleading and confusing. Exactly what do 18,000 incidents entail?

CASP would support HR 5347 regarding the reporting of children placed in seclusion in order to better understand statistics as reported and for data analysis.